Menopause — MHT Prescribing & Monitoring

Choosing therapy, special scenarios & follow-up

CLINICAL PATHWAY

MHT choice follows the **Ws** — who, what, when/how long, and why. Route and dose are tailored to symptoms and risk factors, not a fixed protocol. Exact strengths, brands and PBS listings change and sit at pbs.gov.au and the current product information — not reproduced in this summary.

THE Ws OF MHT PRESCRIBING

Who	Bothersome vasomotor, psychological or urogenital symptoms affecting quality of life, with no contraindication on screening.
What	Estrogen alone if no uterus; estrogen + progestogen if the uterus is intact, for endometrial protection. Vaginal estrogen alone if urogenital symptoms only.
When	Start once symptoms warrant treatment; reassess benefit & risk at least annually — no mandated stop age or fixed duration.
Why	To relieve symptoms and support quality of life; bone protection is a secondary benefit, not the primary indication for most women.

ESTROGEN — ROUTE PRINCIPLES

- Transdermal (patch/gel) preferred over oral if VTE, migraine, liver or cardiometabolic risk factors — lower thrombotic risk.
- Oral is simplest and effective for lower-risk women without these factors.
- Vaginal estrogen treats urogenital symptoms with minimal systemic absorption; usually no added progestogen needed even long-term.
- Dose is titrated to symptom control, not by weight or a fixed schedule.

PROGESTOGEN — CHOICE PRINCIPLES

- Always required with systemic estrogen if the uterus is intact, to protect the endometrium.
- Micronised progesterone is commonly preferred — favourable metabolic profile and may aid sleep.
- The levonorgestrel IUD gives effective endometrial protection plus contraception — useful in perimenopause.
- Match regimen to cycle status: cyclic progestogen with cyclic estrogen, continuous with continuous combined.

SPECIAL SCENARIOS

POI (under 40) generally needs higher-dose, longer-duration MHT to around age 51, with bone & cardiovascular monitoring. Surgical menopause (especially under 45) is managed the same way unless contraindicated. BRCA1/2 or Lynch carriers and most breast cancer survivors need an individualised, specialist-involved discussion before starting MHT.

FOLLOW-UP & DURATION

- Review at 4–6 weeks, then 3 and 12 months, then annually while continuing therapy.
- No fixed stop date — continue while benefits outweigh risks for that individual, reviewed yearly.
- If stopping, taper over 3–6 months; restarting or switching formulation is reasonable if symptoms recur.

EXACT DOSES, BRANDS & REGIMENS

Estradiol patches/gels/tablets, micronised progesterone, and combination products vary in strength and brand — confirm current PBS listing, dose equivalence and product information at pbs.gov.au and the AMH before prescribing.

■ SAFETY

- Breakthrough bleeding in the first 3–6 months of continuous combined MHT is common and usually settles; new bleeding after this, or any unscheduled bleeding on a cyclic regimen, needs assessment.
- Don't stop MHT abruptly for a planned change — taper or cross-titrate to avoid a rebound surge in symptoms.

■ RED FLAGS / REFER

- No meaningful improvement despite an adequate trial and dose/route adjustment.
- BRCA1/2 or Lynch carrier requesting MHT — involve familial cancer genetics/gynae-oncology.
- Surgical or premature menopause under 45, or complex intolerance requiring specialist titration.

Companion to WH-05A (assessment & risk stratification). Summary guidance only — doses & brands are not reproduced here.
Verify against AMS guidance, the IMS 2024 White Paper and NICE NG23; confirm exact products at pbs.gov.au and menopause.org.au.